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ABSTRACT

Intended for parents, the interview with T. B. Brazleton discusses aspects of child mental health, including the difference among babies, the hyperkinetic infant, the baby's influence on the parent and vice versa, laying the groundwork for competency in children, and community programs for parents. (BB)

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Q's & A's on Child Mental Health

An interview with Dr. T. Berry Brazelton

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Q's AND A's ON CHILD MENTAL HEALTH

An Interview with Dr. T. Berry Brazelton

Dr. Brazelton is a pediatrician in Cambridge, Massachusetts, Associate Professor of Pediatrics at Harvard Medical School, and Chief of the Child Development Unit of the Children's Hospital Medical Center in Boston. He is the author of three books for parents and others who are interested in the details of child development. In *Infants and Mothers* and *Toddlers and Parents* he traces the development of three types of babies—average, quiet, and active—from birth through the first 3 years. In *Doctor and Child* he shows how a children's doctor deals with the problems presented by his patients and their families.

In this interview, Dr. Brazelton answers questions about:

- Differences among babies, from birth onward
- The hyperkinetic infant and child
- The baby's influence on the parents and vice versa
- Laying the groundwork for competency in children
- The root of the trouble when something goes wrong
- The failure-to-thrive syndrome
- A community program to make better parents

The interviewer is Herbert Yahraes, who for some years has reported for the National Institute of Mental Health on mental health research and services.

Q: *Doctor, I wonder what lessons can be drawn from your work. You've observed children from infancy on up to—how long is it?*

A: Well, I've been working with them up to 16 and 18 in my practice, but in terms of looking at them from a research standpoint, I work with them only in infancy and up to 2 and 3 years of age. The main reason I started to look at babies was the feeling I had that they influence their environment as much as the environment influences them. And I wanted to identify what it was about the baby that made the mother and the father shape themselves to him, rather than

vice versa. The old idea was that babies were lumps of clay, ready to be shaped by the environment, for better or worse, and I've just never felt that was true. I always felt that when we looked at parents with their infants we were looking at an interaction and that babies were born with very strong individual differences. A baby was born with very strong ways of reaching out for the environment and telling the people in it what was going on, telling them what he needed. I think the environment responds to that in particular ways. A very active baby demands that the parents adjust to his activity and to his overreactions. A very quiet baby demands a set of parents who will respond to him in another way.

Q: *What causes the difference between these types? Is it a matter of heredity, or a matter of fetal experience, or—*

A: I think it is partly heredity and partly the experience in the uterus. We know now that malnutrition in the uterus has a very powerful effect. We also know that drugs in the uterus, and probably the mother's emotions and experiences while she's carrying the baby, shape the baby long before delivery. It is very important for us not only to understand the effects of such things but also to be able to assess these effects in the newborn infant. This is what the neonatal scale I've developed seeks to do.

Q: *We know this? It's not just a matter of inference?*

A: No, no. We know it now. We're not guessing any longer.

Q: *Can you tell me about the neonatal scale?*

A: It enables us to assess not only the neurological integrity of newborn babies but also their individual differences at birth. So it helps us to predict how they are going to influence their parents and whether or not their parents are going to be able to adjust to them. In terms of prevention, it has very powerful implications. That's because I happen to believe that most hyperkinetic children could be saved the tortures

they go through in school and in society if parents were guided and supported in their efforts to help the child early to learn how to cope with his overreactions. I think by the time he got to school, he could probably deal with a lot of the trouble himself. He might still have to blow off steam at times, but I don't think he'd be the misfit in society and have the terribly poor image of himself that most such children have by the time they get to school.

Q: *What causes this hyperkinetic syndrome?*

A: That's a big question. I don't think anybody knows the answer to that.

Q: *Someone wrote that experiences during pregnancy and at birth would have an effect.*

A: A lot of factors probably influence it and maybe set it up. But since we don't know the cause, I think it is important that we do know how to recognize a baby in early infancy that's liable to be hypersensitive and hyperkinetic and that we help the parents not only adjust to him, which is so hard to do, but also perhaps teach him to adjust to himself.

Q: *What specifically could the parent do?*

A: Teach him how to calm himself and how to deal with his overreactions and with his hypersensitivity—to sound, sights, all sorts of things—which usually is a large part of the problem, for hyperkinetic children are usually hypersensitive children.

Q: *That would be a hard thing to do?*

A: Sure, but not by any means impossible. It's a matter of getting on the child's wavelength and showing him how to deal with what he's got to deal with.

Q: *Would you tell the parent about it through such programs as the Brookline Early Education Project, or BEEP? You're a consultant there, I think. As I understand it, in this project a teacher-consultant from the public school system goes into the homes of newborn babies—if the family has volunteered for the program—and helps the parents right from the start*

to raise competent and emotionally healthy kids. The teacher-consultant works with the parents until the child is 5. This is in a Boston suburb.

A: Yes. BEEP is one kind of outreach program, and I think that any outreach program having as its primary goal the prevention of psychological difficulties could be tuned up to do that sort of thing—to work with parents and play a sort of advocacy role.

Q: *Hyperactivity can be recognized in infants, now?*

A: We can tell a lot in infancy, yes.

Q: *What happens to children with hyperkinesis as they grow up? Do they outgrow it by the time they are 20, say?*

A: They outgrow this tendency to hyperactivity, yes. The trouble is that they have such poor self-images by then—because they've had to struggle so hard and they've always been failures—that many of them have major psychological difficulties.

Q: *Could you think of a case that would illustrate that? Have you treated a child who's having psychological difficulties in adolescence as a result of hyperkinesis?*

A: I'm not a psychiatrist; I'm a pediatrician. But I've certainly had a number of children in my practice who have suffered greatly. I had a 14-year-old girl who always had to struggle with learning problems as well as with symptoms of hyperkinesis. Finally at 14, she was beginning to calm down, was beginning to make it in school, was beginning to pull everything together. And I said, "Gee, you've really had a tough struggle, haven't you? But you've finally done it." And her eyes filled up with tears and she said, "You understand, don't you?" From that child's standpoint, the struggle had been indeed a major one.

Q: *How was hyperkinesis manifested in that case?*

A: She just had a hard time sitting down to be taught in school. She was always jumping around, interrupting the teacher, running around the room, reacting—overreacting—to everything that went on.

Q: *Did you treat her with drugs?*

A: I did not. I treat only about 5 percent of my practice with drugs.

Q: *I thought drugs for hyperkinetic children were very widely used.*

A: I think they are too widely used. I think that by the time most hyperactive children are referred to physicians—at 5 or 6 or whenever—it is already too late to work on them in a preventive way. That's why I say intervention ought to start in infancy.

Q: *One of your papers for scientific journals gives the history of a girl named Mary. She was very normal at birth—*

A: Then withdrew.

Q: *Yes. The mother didn't seem to have the usual affection for the girl and handled her rather gingerly. So Mary began to go downhill. A neurologist was disturbed about her. Eventually, though, when the mother got the report from the neurologist, she somehow picked up and gave the girl better care in this case. I take it the mother was influencing the infant, rather than the other way around.*

A: Yes, but the infant may well have been susceptible to begin with. Even though she seemed normal to us in the neonatal nursery, she probably was vulnerable. She was a quiet infant, and she allowed the mother—who was in a severe depression—to withdraw from her. If Mary had been more vigorous and cried harder and fought harder, she might have gotten the mother back to her rather quickly. Instead, she, too, began withdrawing. By the time she was 4 or 5 months old, she was doing so in a serious way and might well have ended up as an autistic or an atypical child in the back ward of some mental hospital. So the cause of the trouble was neither solely the mother nor solely the infant.

Q: *Has that baby turned out all right?*

A: She's all right, yes, in the sense that she is not defec-

tive or retarded, or autistic, or atypical. She does have school problems and adjustment problems.

Q: *And these trace back to how she and her mother got along early in life?*

A: I think so.

Q: *And apparently nothing happened during birth to cause physical damage?*

A: Nothing that we could detect. We thought she was normal neurologically.

Q: *I've often read about one problem or another being attributed to complications of birth or pregnancy.*

A: Yes

Q: *I've been reading papers by Dr. Arnold J. Sameroff, professor of psychology and pediatrics at the University of Rochester. He said something to the effect that studies which look back over a person's life—retrospective studies—are always digging up these so-called causes, while studies that start early in a person's life and keep following it—prospective studies—do not find these causes. Have I got that right?*

A: As I understand Arnie Sameroff, he is saying that so many factors enter into producing abnormal behavior that to blame one factor or another is to miss the boat. It is usually a combination of things, one of which may be a disturbed mother. For instance, he says that a schizophrenic mother is more likely to be taking drugs—for her condition—and to have a difficult delivery. When you combine the various factors—drugs, perinatal difficulties, and maybe a vulnerable infant—and add a schizophrenic mother, you've got a setup for failure in the interaction between mother and child. What he is saying, I think, is that there are many factors that we don't fully understand—too many for us to be as simplistic as we used to be when we blamed a condition on one cause, either nature *or* nurture. But I think that if we are alert for all the factors that may place a child at risk to mental illness, we are more likely to get in and do something about it before it's too late.

Q: *You did some studies in Guatemala. Can you tell me how the Guatemalan infant differs from the American infant?*

A: The nutritionally deprived neonates that I studied turned out to be very quiet, unresponsive. The mothers were a poverty group and weren't eating properly, so the babies had already suffered malnutrition by the time they were born. They were very quiet and difficult to arouse.

A person didn't feel like talking to them or playing with them. Since they just weren't very exciting infants to play with, there was a great chance they would be neglected or pushed into the back room by a mother who didn't have enough food for herself and who had too many children and too much poverty to deal with.

Q: *Then here is a case of the baby affecting the mother, right? And then of the mother reacting, so they're both affected?*

A: They affect each other. This is my whole thesis. I think this is usually the case. But, as a pediatrician, I think we ought to be looking for how much the baby contributes to the interaction and how much the mother contributes, and we ought to be constantly watching to see the strengths and weaknesses in each of the participants.

Q: *You did a study in Africa, too. As I understand it, the babies were born listless and the mothers had to work to get them to react.*

A: These, too, were a nutritionally deprived poverty group. But the mothers were not as brainwashed by their poverty and deprivation—they were first-generation poor. And they played with their babies, *expecting* them to improve—which they did, as soon as they began to get nourished by breast milk. Maybe they will be more vulnerable later on. If a mother has a good image of herself and passes that on to the baby, it pays off. It is in poverty groups where the mother is already beaten down by her situation and

has already got a lousy image of herself—which she passes on to the baby quickly—that the hopelessness and the helplessness of poverty get recycled, generation after generation.

Q: *You used the term "intrauterine depletion." What does that mean?*

A: It means that the baby in the uterus wasn't getting enough nutrients across the placenta. Either the placenta was playing out—wasn't serving the child properly—or the mother's intake of nutrients wasn't adequate for the baby.

Q: *You have written somewhere that parents of children admitted to wards at Children's Hospital are often successful parents of other children. And they say they've never been able to understand this child. What has gone wrong? Why are they successful parents of other children, yet have a child that isn't normal?*

A: The trouble may be primarily with the baby. I keep asking in such a case whether there hasn't been something about the baby himself that made it difficult for them to reach him or her.

Q: *Can you tell me about a family like that?*

A: I can tell you about a kind of baby. We have talked about babies who have been born into undernourished and deprived families. But sometimes even mothers who have been eating all right and have been getting what seemed to be proper care have babies who have been somewhat deprived in the uterus. One reason is that the placenta may have failed; there are many other reasons. The result is what we have called a "small for gestational age"—or SGA—baby. Such babies are very difficult to reach as neonates. They very often turn off their mothers—make it very difficult for the mothers to get through to them and begin to pull them along.

Q: *It was interesting to note that an infant alerts and attends to a female voice in preference to a male voice.*

A: Yes. We place a baby on his back and let him look up at the ceiling. Then I talk to him. And when I talk, his eyes will alert and his head will turn and he'll look around for my voice. Then if I've got a female nurse, and we both talk at the same time, he'll turn toward her, every time, rather than to me.

Q: *How do you explain that?*

A: I think babies are programed to be more responsive to certain kinds of information—particularly information about the mother—than to other kinds of information. They try very early to capture the mother's attention. Presumably they know that if they turn to her voice, she is sure to respond. I think babies are set up with many programs that are ready to go into operation at birth.

Q: *Is this something that's generally known among pediatricians and psychiatrists?*

A: It's getting to be.

Q: *Do your studies show anything about what helps children to achieve competence and fullness—to realize their potential?*

A: Well, mine are all aimed at the mother-infant, father-infant interaction which provides the groundwork for whatever is competence later on. If the mother and father have a good relationship with the baby and give the baby a good feeling about himself—give him the feeling that he is competent, that he can do things, that what he does is really on target—then I think the baby develops a sense of competence about himself. This begins to fuel itself, and when the time comes, he can begin to pick up and act upon environmental cues and learning tasks and to get the feedback from within: "Gee, that was just what I needed to do! Isn't that exciting?" That kind of inner excitement, which has been fueled by responses to the environment, is where I think competence starts.

Q: *If a parent or a prospective parent said to you, "Doctor, I want my child to be a competent person and to realize his full potential—what steps should I take to*

ensure that?" what would you tell her?

A: If a mother asked me that, I would immediately begin to wonder if she'd fallen into one of the traps that some psychologists have laid for young women in our society. These psychologists say that you've got to do the right thing at the right time or you're going to be in trouble, and I think that's a trap. I believe that every parent would like to develop a competent, contented, happy child. But if they start doing it artificially or instrumentally by trying to present the right stimulus at the right moment, I believe also that they are a lot more likely to fail. What's important is that they see themselves as important people to this baby and try to understand the baby as a person and fit themselves for interacting with this baby. All this gives them a feeling that they are doing the right thing and gives the baby the feeling that he is doing the right thing. Real affective, or emotional, interaction between parents and child is more important than the cognitive stimulation kick that everybody's into right now. I think that's important, too, but I think it comes second to the other.

Q: *We were talking about the Brookline Early Education Project. What kind of advice does BEEP give to the parents?*

A: In my opinion, the best thing about BEEP is what they're doing in early prevention in infancy. We are getting back to the earliest interaction between parent and child. We are supporting young parents by helping them to see what is needed and giving them enough information to go on. Thus we help give them a feeling of confidence so that by the time they get to the stimulation period—set by the psychologist—they know what their baby is like, what they are like, and what's important between them. I think that's where support has to be given—way back in the beginning, not at 9 months or 12 months or 2 years or anything like that. If you want emotionally healthy children, I think you support those young parents who feel inadequate about childrearing—and in our society all

young parents feel inadequate. They feel sort of lost and at sea; they don't have enough support. Middle-class parents, lower-class—any class—need what we've got to offer. But we need to offer it to them way back when they're first starting off with their babies.

Q: *The people who are working in this project, actually working with the families, do they have a text or materials of some kind?*

A: They have a curriculum, right. It's concerned mostly with the first few months—with supporting mothers, seeing what they're doing, giving them ideas about their baby, and answering their questions. So, it's more of a support system in the beginning. Then, later on, it becomes aimed at education and stimulation. As I say, I may be prejudiced, but I think that what you do to help mothers and fathers in the beginning is more important than to give them a program for stimulation later on.

Q: *When something goes wrong in child development, what is it likely to be?*

A: At the base of what might be going wrong, I would say, is a failure in the interaction between parent and child.

Q: *Would the major factor be lack of interaction, or the wrong kind of interaction?*

A: I think it's a failure in interaction, not a lack of it. And the failure could come because of a difficult or fragile or overreactive baby, or it could come because of a mother or father who was extremely depressed or insensitive or unable to fit this particular baby. I think this is what a person with a preventive approach ought to be looking for: Where is the trouble coming from? If things aren't going right, what's going wrong? This is what we're working on here in our child development unit. We're trying to develop techniques for predicting trouble before things have actually gone wrong, not afterward. Once you have pathology, you must set up a therapeutic program that will be difficult, prolonged, and expensive. I have a feeling that if we could get in earlier and take pre-

ventive measures, we could eliminate pathology—not all pathology but a lot of it.

Q: *As a pediatrician do you run into psychosis in children?*

A: Not very often.

Q: *How about depression?*

A: There are infants that are depressed. Usually that's because of inadequate interactional situations at home. Often, too, such infants aren't being properly nourished: either they are being underfed or they are not digesting the food because they're so depressed.

Q: *Can you think of such a case?*

A: We have many cases of what we call "the failure-to-thrive syndrome" here at the hospital. Such babies usually come in at somewhere between 4 and 8 months. They're still weighing what they did at birth, and they're looking starved and depressed and turned off.

Q: *What do you do?*

A: We start working with the baby first, by giving him one nurse, or one care-giver, who can interact with him and who can gradually bring him back into contact with his environment. Most of these babies are so turned off that they can't take anything from the environment in the way of stimulation. By feeding them and sensitively handling them—realizing that they have a raw central nervous system from having had a failing environment all this time—we can gradually, over a week or 10 days, bring them back into interaction with the environment, especially with a particular person.

Q: *You do that here in the hospital?*

A: Yes. By that time, hopefully, the mother's in some sort of treatment or helping situation, so she can get herself reorganized. We like to bring them back together, eventually.

Q: *Who works with the mother?*

A: A social worker, usually, or a psychiatrist. A social worker can do it, usually, if the mother can be

reached. Some, though, are unreachable because they're either depressed or so frightened or turned off that they run away. They know the baby has been neglected, essentially, and they're very frightened about that.

Q: *So it's a pretty big and expensive job.*

A: It surely is. But at least with these million-dollar workups and treatment programs, we're saving a lot of babies—and mothers.

Q: *So that BEEP might prove to pay its own way by eliminating the need for so much treatment?*

A: Sure. I think any good comprehensive outreach program, and that's what BEEP is, can do a lot of prevention. The only trouble with BEEP—and this is true of almost any of these outreach programs—is that we're really not yet reaching the target population. The most deprived and most needy people can't even relate to BEEP.

Q: *Brookline is a pretty high-up community?*

A: Middle-class.

Q: *And you're bringing some lower-class people into the program?*

A: We are. But the people who need help the most are the hardest to reach. It takes a very sensitive and rather expensive attempt to reach people like that, and I'm afraid we may be missing a lot of them. We haven't got the tools yet; medicine isn't a very good tool for reaching troubled people.

Q: *Do you feel that programs like BEEP should be started throughout the country even before all the findings are in?*

A: Sure. But I think everybody ought to be thinking about his own kind of outreach program. BEEP is just one kind. It probably will be more successful than many others because it is managed by educationalists who are already in touch—through the schools and the older children—with a lot of the population that medicine never reaches. Also, I think any program that has a multidiscipline approach is bound to do a

better job than one that relies on just medicine, just nursing, just the hospital outreach.

Q: *You've written about minimally brain-damaged, or MBD, babies. Do you use that term when you're talking with a parent?*

A: Sure. If I have a baby that I think is really at risk, I certainly do. It's amazing to me how many parents know it already. We may have thought we were hiding it from them, but we were wrong. By trying to hide it from them, we are really putting them down. We are saying "You don't deserve to know this" or "You can't handle it." And this is terrible, because you are just devaluating the parent. I think we have been going at it in an entirely wrong way, and it's time we changed.

Q: *You've said that MBD children make remarkable compensatory recoveries in a first-rate environment. How do you know this?*

A: An extensive body of research shows that babies, including MBD babies, do much better in an environment that understands them and has realistic expectations for them. In such an environment, the parents know that the baby may have problems, and they are helped to deal with them. A while back I was talking about a hyperactive child. If you reacted to such a child as you would to a completely normal child, you'd overload him; he'd get disturbed, and you wouldn't reach him. Working with an MBD baby takes a very sensitive kind of handling, one that recognizes where the baby is, not where you wish he were.

It is critical that the parents understand the child, really work with him as he is, and give him credit for his accomplishments. When they do that, they are going to pass on the message we were talking about: "Gee, you're great!" Then the child will develop a good self-image, which is so much more important than whatever defect he may have. And the child will

come through equipped to handle whatever it is—hyperkinesis, cerebral palsy, learning disability, or anything else that the environment can either worsen or ameliorate.

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